# LOS ANGELES COUNTY COMMISSION ON HIV

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## STANDARDS OF CARE (SOC)
## COMMITTEE MEETING MINUTES

October 4, 2012

| MEMBERS PRESENT | MEMBERS ABSENT | DHSP STAFF | COMM STAFF/ CONSULTANTS |
|---|---|---|---|
| Angélica Palmeros, *Co-Chair* | Lilia Espinoza | Thai Dao | Jane Nachazel |
| Fariba Younai, *Co-Chair* | Jocelyn Woodard/Robert Sotomayor | Terina Keresoma | Craig Vincent-Jones |
| Vivian Branchick | | Rafeeq Rahim | |
| Mark Davis | | Jenell Ross | |
| David Giugni | | | **PUBLIC** |
| Terry Goddard | | | None |
| James Jones | | | |
| Carlos Vega-Matos | | | |

**CONTENTS OF COMMITTEE PACKET**

1) **Agenda**: Standards of Care (SOC) Committee Agenda, 10*/4/2012*
2) **Minutes**: Standards of Care (SOC) Committee Meeting Minutes, *7/9/2012*
3) **Minutes**: Standards of Care (SOC) Committee Meeting Minutes, *9/6/2012*
4) **PowerPoint**: Division of HIV and STD Programs HIV Care Services, Substance Abuse Services Overview, *10/4/2012*
5) **Standards of Care**: Los Angeles County Commission on HIV, Standards of Care, Substance Abuse Treatment, Final, *10/13/2005*
6) **Standards of Care**: Los Angeles County Commission on HIV, Standards of Care, Substance Abuse Residential, Final, *10/13/2005*

1. **CALL TO ORDER**: Ms. Palmeros called the meeting to order at 10:12 am.

2. **APPROVAL OF AGENDA**:
   **MOTION #1**: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES**:
   **MOTION #2**: Approve the 7/9/2012 and 9/6/2012 Standards of Care (SOC) Committee meeting minutes **(*Passed by Consensus)***.

4. **PUBLIC COMMENT, NON-AGENDIZED**: There were no comments.

5. **COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

6. **CO-CHAIRS' REPORT**: There was no report.

7. **SUBSTANCE ABUSE SERVICES**:
   A. **Substance Abuse and Addiction Medicine**:
      - Mr. Vega-Matos said the DHSP substance abuse team has reviewed the portfolio for a year to ensure appropriate services for the population going forward. The PowerPoInt briefly reviews the current portfolio and proposed changes.
      - DHSP now has eight agencies overall that support: Residential Detoxification, 14 days, 3 agencies; Residential Rehabilitation, 56-120 days, 8 agencies; Transitional Housing, up to 120 days, 2 agencies; Day Treatment, 90 days, 3 agencies. Providers may submit an extension request beyond the 120 day maximums with certification of need.

- DHSP providers are: Behavioral Health Services, Cry Help, LA CADA, South Bay Mental Health, Substance Abuse Foundation, Tarzana Treatment Center, Van Ness Recovery House and Watts Healthcare Foundation. The latter assumed the Palms Residential Services contract about three years ago and only does Residential Rehabilitation. All agencies also have contracts with Substance Abuse Prevention and Control (SAPC), Department of Public Health (DPH).
- There were 540 unduplicated clients with 407 new clients in YR 21, 3/1/2011-2/28/2012. There were 320 unduplicated clients with 187 new clients in YR 22 to date, 3/1/2012-7/31/2012. "New" clients are new to the agency and new to treatment that year. There was a reduction in service utilization over the last two or three years due to state reductions to feeder programs in 2009. DHSP is working with agencies to increase referrals, recruitment and retention.
- Challenges include the service utilization issues, e.g., referral processes are not straight forward and agencies tend not to be proactive in recruitment. There are issues with recidivism and ensuring people comply with treatment services.
- There are also multiple program/service design issues. Current services were constructed after the Mercer rate study, but some things about the study are odd. For example, Residential Rehabilitation is divided into low, medium and intensive services, but this service is intensive by nature. There are also service gaps, e.g., there are no funded outpatient services to provide a step down to aftercare services once funded services are completed.
- Staff capacity is uneven with credentials, training and experience varying widely. For example, substance abuse service providers often hire people in recovery as counselors, but guidelines for such hires are inconsistent requiring varying combinations of years in recovery and/or training program. Staff and leadership are dedicated, but unequal.
- Program efficacy cannot be measured as the only performance measure is treatment days not independent markers.
- Not all providers can address multiple morbidities and there is no uniformity among those that do. Co-morbidities in the HIV+ population include not only substance abuse and mental health, but others such as sexual addiction and Hepatitis C. Stronger coordination with medical providers is needed including linked referrals.
- The programmatic framework of most County providers is a social model. Many resist incorporating addiction medicine such as using biometrics and contingency management, e.g., Plan B for women. DHSP wants a robust assessment, a robust treatment plan and documentation in notes. SAPC, however, is the larger funder and does not require that approach. SAPC is working on changes to their portfolio and DHSP will present to them on possible improvements.
- DHSP is developing a new treatment framework that provides:
    1. Evidence-Based and Promising Practices including individualized treatment plans, addiction medicine, independent accreditation such as via Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), increased staffing certification/credentialing requirements and harm reduction for PLWHA not ready for full scale treatment;
    2. Treatment of Multiple Morbidities including mental health and contingency management and better coordination with medical providers;
    3. Outcomes Focused programs.
- Mr. Vincent-Jones noted JCAHO (The Commission) accreditation would be difficult for some community providers such as Van Ness Recovery House. Mr. Vega-Matos replied some providers already are seeking JCAHO accreditation, but there are different models to address addiction medicine such as linkages between community and medical providers. Significant research supports addiction medicine such as medications that help address cravings in early treatment.
- Dr. Younai said significant literature also supports behavioral interventions. Mr. Vega-Matos said the framework will not abandon behavioral interventions, but add to them. Current social models may or may not be based on valid behavioral interventions. This will be a process just as transitioning to Medical Care Coordination (MCC) was a process.
- Mr. Vega-Matos suggested a new framework that includes a full continuum of substance abuse treatment services:
    1. Inpatient Detoxification (Detox) in an acute care facility to ensure medically safe withdrawal when there is risk of severe withdrawal symptoms or seizures and/or severe co-occurring medical or mental health conditions. Length: 5-21 days or up to 28 days for more complicated cases with flexibility to extend treatment with approval. Currently the system only provides 14 days.
    2. Residential Rehabilitation (RR) provides 24-hour, intense, structured, monitored services in a residential setting for those who do not need 24-hour medical supervision, but present with biomedical (e.g., HIV, HCV, diabetes) and behavioral problems (e.g., bipolar, major depressive or psychotic disorders) significant enough to require residential treatment. Length: 4-7 months.
    3. Partial Hospitalization-Day Treatment (PHP) provides services for a minimum 20 hours per week and can provide less intense addiction treatment for those recovering from severe and/or chronic behavioral health conditions. They can be a step up from outpatient or a step down from acute inpatient or residential services. Length: 28 day maximum with flexibility to extend with approval. Minimum hours: 20 per week.

4. Intensive Outpatient Program (IOP) provides hospital-based, half-day (I.e., four hours per day) services in an ambulatory setting for those recovering from severe and/or chronic addictive behaviors. This can be a step up from routine outpatient or a step down from acute inpatient or residential or PHP. Length: 45-60 days maximum, no extensions. Minimum: 9 hours per week.
5. Basic Outpatient Program (BOP – Aftercare) is patient treatment in an ambulatory setting to assess and treat addiction, e.g., substances, gambling, food, sex. Length: 60-90 days, no extensions. Minimum: 3 hours per week.
6. Transitional Residential Services (TR) provides temporary, 24-hour supervised patient treatment and housing in an ambulatory setting to assess and treat addiction and other co-morbidities (i.e., HIV, HCV, psychiatric illness). They provide an opportunity to learn how to manage activities of daily living and can be complemented by concurrent PHP, IOP, BOP and community-based support program participation. Length: 3 month maximum, no extensions.
7. Residential Harm Reduction Model provides a Contingency Management structured environment for those in the pre-contemplation or contemplation stage regarding treatment to reduce HIV transmission among PLWHA or HIV- people at high-risk not ready for substance abuse treatment. Length: 1-2 years maximum, no extensions. This may be the most controversial aspect of the continuum as it serves those still using, but it prepares patients for treatment via case manager coordination with medical homes to develop interventions.
8. Full Spectrum Addiction Case Management (FSACM) permits assessment and proper matching of patient need with various levels of treatment, reduces redundancy of failed treatment options and professionally oversees treatment at all levels of care and across all diseases. Length: duration of treatment. Case managers will be trained, certified and licensed clinicians, preferably at the masters level or above, with experience in both addiction and mental health. The Substance Abuse and Mental Health Services Administration (SAMHSA) has such specialized trainings and certifications. FSACM will maintain strong coordination with MCC if pertinent.
9. Interventionist Services work with others in the lives of those who are pre-contemplation/contemplation regarding addiction, psychiatric illness and/or HIV status to reduce or eliminate enabling, introduce patients to addiction treatment by meeting them where they are and offer motivation to and an appropriate avenue of change. The goal of these services is to break the addiction cycle. Length: Duration of treatment, as needed.
10. Sexual Addiction Assessment and Treatment Services (SAAT) provide a form of treatment designed to assist in HIV containment within and across patients for those HIV+ or high-risk HIV-. Assessment identifies if behavior is sexual addiction or, e.g., consequent to substance abuse. Singling out sexual addiction for treatment is appropriate since sexually transmitted HIV is the main driver of the County's epidemic and there is a high rate of HIV/STD co-infection. Length: Duration of treatment, as needed. Services may be separate or integrated into others.

- These services not only treat addiction, but also address chronic diseases in an integrated public health approach.
- FSACM acts as system navigator for all services via assessments, determination of initial level of placement based on individual patient need and approval of subsequent movement through the continuum based on patient need. FSACM may or may not be via an independent provider, but will be familiar with all providers for optimal placement.
- DHSP is considering requiring all providers to offer the full continuum aside from harm reduction services which are distinct by nature. That is not the case now and can impede smooth patient transitions through the continuum.
- Mr. Giugni asked why psychosocial case management was just merged into MCC, but now substance abuse is being separated out. Mr. Vincent-Jones noted some kinds of specialty case management were anticipated, e.g., for housing. This is another such area due to the expertise required, but it continues to coordinate with MCC and medical homes.
- Dr. Davis expressed concern about access. Mr. Vega-Matos noted only about 600 patients were served now. The new model will be more cost effective by ensuring patients are ready for a particular level of treatment rather than entering and falling out of care. Mr. Vincent-Jones added the model must be developed first. Allocations are a separate issue.
- The substance abuse continuum includes multiple outcome measures:
  - □ Biometrics can be used effectively such as for random tests to verify reported sobriety when attending groups or to help delay HIV seroconversion for high-risk HIV-, gay/transgender meth users;
  - □ Behavioral markers such as coping skills;
  - □ Standardized use of Global Assessment of Functioning (GAF) scores;
  - □ Engagement in HIV care is a key metric. One impetus for MCC development was data showing many psycho-social case management clients were not receiving such care underlining the need for coordination;
  - □ Vocational markers such as for work force re-entry or educational development;
  - □ HIV status for HIV- patients.

- Mr. Vega-Matos noted biometrics expenses were not built into the rate study as they were not being done at the time. The DHSP team has extensive experience in this field and has collected pricing information for appropriate tests and pertinent medications. Mario Pérez, Director, DHSP, considers improving substance abuse treatment a priority.
- Mr. Vincent-Jones reported the Substance Abuse Treatment and the Substance Abuse Residential Standards of Care were both last revised in 2005. They can be redone either via an Expert Review Panel (ERP) or in the SOC Committee.
- Mr. Vega-Matos said rates will also have to be revised. DHSP is considering doing that in-house especially as current provider costs reflect the old program. Mr. Vincent-Jones recommended a previous Commission consultant to help.
- Mr. Vincent-Jones noted if an ERP is used, a draft has to be prepared for the deliberations. Dr. Younai emphasized better coordination. Last time the draft had to be significantly revised after the ERP to reflect rate study changes.
- Mr. Vega-Matos said DHSP continues to flesh out the continuum and will vet concepts internally. Mr. Vincent-Jones felt it important for the SOC Committee to review the draft prior to formal presentation to others, such as providers.
- ➲ Mr. Vega-Matos will revise behavioral problem examples under Category 2. Those listed are psychiatric illnesses.
- ➲ Mr. Vega-Matos will review inclusion of "no extensions" with some category maximum lengths. DHSP included it to encourage patients to move through the continuum, but Mr. Vincent-Jones felt it over-emphasized limits.
- ➲ Mr. Vega-Matos noted the PowerPoint excluded the high level of provider requirements due to space, but the team will review that, e.g., medical director, licensed mental health clinicians and a high substance abuse certification level.
- ➲ Mr. Vega-Matos will include a slide showing the patient moving through the system.
- ➲ DHSP will consider replacing the PowerPoint diagram with intersecting circles or a Venn diagram.
- ➲ Mr. Vincent-Jones and Mr. Vega-Matos will coordinate on draft development with a goal of completion in 2013.
- ➲ The SOC Committee will review the draft rather than establishing an ERP to do so.

**B. Review of Current Standards/Rate Study**: There was no discussion.

**8. STANDARDS OF CARE**:

**A. Vision Services**:

- Mr. Vincent-Jones reported the Commission has invited the following for the Vision Services ERP: Dr. Joseph Cadden, Medical Director, Rand Schrader Clinic; Dr. Phan, Royal Vista Family Health Center; Dr. Vejas, Queen's Care; Dr. Nicano, Optometric Center LA; Dr. Peeks, Valley Community Clinic; Dr. Morana, Los Angeles Eye Center; Dr. Sonali Kulkarni, Mr. Vega-Matos and David Pieribone, DHSP.
- He has called Chris Brown, LA Gay and Lesbian Center and the California Board of Optometry. He will also invite an AIDS Health care Foundation representative.
- Mr. Goddard asked about the HIV nexus. Mr. Vincent-Jones said there is no optometry HIV specialty, but optometrists may see HIV complications so the standard can raise awareness and improve linkage to care.
- A pharmacist was previously suggested to address potential points of entry, but has not been identified.
- ➲ Mr. Vincent-Jones will invite his optometrist at Kaiser.
- ➲ Mr. Vincent-Jones will have Dawn McClendon coordinate with Mr. Giugni on a letter to invite Ruth Tidel, Capitol Drugs and Member, Lesbian and Gay Advisory Board, City of West Hollywood. If she is not available, Brenda will be invited.
- ➲ Mr. Giugni will invite Michael Arrigo, Member, Consumer Advisory Board.

**B. Linkage to Care**: There was no discussion.

**9. NEXT STEPS**:

- Mr. Vincent-Jones reviewed the agenda for the next meeting: Dr. Kulkarni, DHSP, will present on the Medical Outpatient (MO) Standards of Care; Dr. Martin will present on incorporating medical marijuana recommendations into the MO Standards; and the SOC Committee will develop a timeline for revising standards.
- Mr. Vincent-Jones reported copyediting continues for standards publication. It will be solely electronic due to the decline in use of hard copy materials. The deadline to expend grant funds is 10/7/2012 and all funds have been expended.
- ➲ Expand the 11/1/2012 SOC Committee to 9:00 am to 12:00 noon to accommodate the agenda.

**10. ANNOUNCEMENTS**: The Alliance for Housing and Healing Drag Show fundraiser will be 10/7/2012, 7:00 pm, Orpheum Theatre.

**11. ADJOURNMENT**: The meeting adjourned at 11:55 am.